Sub-temática: Demência e Envelhecimento

Supporting *staff* caring for institutionalised people with dementia: a psycho-educational approach

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Abstract

Background

Caring for people with dementia can be very stressful for direct care staff working in residential facilities, due to residents' challenging behaviours (e.g., delusions, aggression and agitation) and to the insufficient specialized training in dementia care. Despite the association between staff's stress and residents' well-being, the majority of interventions tend to provide staff with education, overlooking the provision of emotional support. Thus, the purpose of this pilot-study was to develop and evaluate a psycho-educational programme (PE) for staff in a residential facility, designed to: i) increase staff knowledge and competences regarding dementia care; and ii) provide staff with coping strategies to manage work-related stress.

Methods

Six staff members of one residential facility of the district of Aveiro (Portugal) participated in 8 psycho-educational sessions of 90 minutes each, held fortnightly, during 4 months. A focus-group interview was held with 5 staff members, 2 weeks after the intervention, aiming to: assess the functional aspects, contents and methodologies of the programme; determine the main benefits and disadvantages from staff participation in the PE; and collect suggestions for the development of future programmes. The interview was video-recorded, transcribed and submitted to content analysis by independent judges.

Results

Participants reported that the programme was well-structured and allowed: i) the acquisition of knowledge and skills on dementia care; ii) the demystification of pre-existing beliefs related to dementia; iii) a higher group cohesion and willingness to share experiences; iv) the acquisition of problem-solving skills related to work demands; and v) the awareness to the importance of their own well-being. The lack of time was highlighted as the major limitation to participate in the programme. Regarding suggestions, regular meetings with all staff to share concerns and difficulties, were emphasised.

Conclusion

Findings highlight the need of interventions that could extend those objectives exclusively targeted to residents' well-being, by also allowing staff to feel supported. Psycho-educational approaches can have a positive impact on staff sense of mastery and self-competency and, therefore, might improve the quality of care and well-being of staff and residents. Further studies, with larger samples and using control groups, are needed in order to investigate the extent of these benefits.

INTRODUCTION

Dementia is one of the leading causes of disability in later life and a strong predictor for care home placement[1]. About two-thirds of people living in residential facilities suffer from dementia, and as many as 90% of them present challenging behaviours (e.g., delusions, aggression and psychomotor agitation)[2].

Direct care staff are the professionals who provide the most hands-on care to people with dementia and mainly contact with residents' challenging behaviours[3]. Although their central role on residents' care and well-being, they do not always have the skills and knowledge necessary to respond effectively to the needs of people with dementia[4-6]. Hence, the assistance they provide tends to neglect the residents' psychosocial needs and the use of physical and/or pharmacological restraints are a common procedure[7-9].

Given this, a growing body of research advocates a *person-centred* approach to dementia care[10, 11]. Such concept places the person with dementia at the centre of the care dynamic rather than his/her health condition. Thus, person-centred approaches maintain the individuality of the person with dementia and recognize the social environment as a therapeutic agent, thereby enabling people to communicate and interact with others[10-12]. Ultimately, the quality of care provided to people with dementia improves, which may result in increased residents' well-being[12].

Motor stimulation (MS) and multisensory stimulation (MSS) have been increasingly used as non-pharmacological approaches to dementia care[12-14]. MS refers to specific exercises to improve mobility[15] and delay the decline of activities of daily living[16]; MSS is an intervention that actively stimulates the senses with no need for higher cognitive processes, and has been shown positive impacts on residents' well-being[12, 14, 17, 18]. These approaches can match the concept of *person-centeredness,* as care providers are recommended to incorporate residents' biographies and individual preferences into care provision, promoting an individualised care.

A number of interventions, usually referred as to *training* programmes, have been designed to provide staff with education about dementia and training in the use of these person-centred care approaches[12-14, 18, 19]. Positive effects on staff knowledge and skills were reported, however, few significant impacts on stress and burnout levels were found [12-14, 18, 19]. This means that, despite staff well-reported stress and burnout[20-22] and its recognised association with the quality of care provided[23] and residents' well-being[24], few interventions provided staff with emotional support. It is therefore critical to develop interventions for relieving stress and prevent burnout on staff members.

Thus, the aim of this study was to develop and evaluate a psycho-educational programme (PE) for direct care staff in a residential facility, designed to: i) increase staff knowledge and competences regarding person-centred approaches to dementia care and ii) provide staff with coping strategies to manage work-related stress.

METHODS

For this pilot-study, participants were recruited from a residential facility of the district of Aveiro (Portugal) which housed 51 residents, 21 of those diagnosed with dementia. The facility administrator was first contacted and informed about the purpose and procedures of the research. Consent to participate in the study was obtained. The implementation period lasted between November 2009 and February 2010.

Participants and recruitment

The service manager was asked to select staff members who maintained direct contact with residents with dementia during daily care provision.

Ten staff members were identified. Potential participants were then individually informed about the purpose of the study and were invited to participate. Nine members agreed to participate. The participation was voluntary and no payments or inducements were offered. Written informed consent was obtained from all participants. Before the

beginning of the programme, 3 participants dropped out (1 due to health problems, 1 for personal reasons, 1 because the person quitted her job).

A total of 6 staff elements participated in the study. Participants were all female with an average age 40 years (SD=11.91), ranging from 22 to 49 years. The academic qualifications of the studied group ranged from primary school (n=2) to higher education (n=2) (Table 1).

Intervention: Programme overview

The design of the programme was informed by two main sources: i) a literature review about training programmes for care staff, psycho-educational interventions, stress and burnout in dementia care; ii) staff's needs and expectations: a focus-group interviews with staff were previously conducted in order to collect information about their perceived needs and difficulties and expectations about the intervention. The findings highlighted the staff's needs for information and skills to improve dementia care, as well as competences to manage stress and coping skills[30].

The programme included 8 psycho-educational group sessions of 90 minutes, held fortnightly. All sessions were conducted by a multidisciplinary team, including a gerontologist and a physiotherapist with experience in person-centred approaches to dementia care, and a psychologist with training in psycho-educational groups. Those embraced the role of facilitators, normalising feelings or thoughts.

Each session comprised an educative and a supportive component (Table 2). The educative component aimed to present basic information on dementia, share communication skills to interact with residents with dementia, and provide competences to increase person-centred approaches to care (e.g., multisensory stimulation and motor stimulation). Several activities were included to facilitate the acquisition of knowledge and skills, such as case-studies, lectures, role-plays or brainstorming. The supportive component intended to help staff to improve: i) self-care competences, ii) emotional management, iii) coping strategies to deal with stress and burnout, and iv) the sense of meaning in their jobs. Participants were encouraged to share their stories, feelings and experiences. With the exception of the last session, there was a moment at the end of the supportive component where relaxation techniques were practised. Home tasks were proposed at the end of each session.

All sessions followed a similar format: i) home task review and participants' reports on the successes and difficulties when performing it; ii) presentation and development of the structure of the session; iii) group relaxation exercise of approximately 10 minutes; iv) proposal of the home task for that week. Handouts with a summary of the most relevant information were provided to participants.

During that week, each staff member was assisted by a gerontologist and a physiotherapist, while providing morning care – upper-body bathing, dressing and toileting. These professionals helped staff to implement the new skills, clarified doubts and made suggestions to improve the quality of care.

Session 1

Participants and facilitators introduced themselves. The educative component started with a brief overview of dementia (e.g., symptoms, progression and treatments) and was led by a physician. At the end, participants had some minutes to raise questions and clarify doubts. Practical questions like how to react and deal with challenging behaviours prevailed. Strategies to stimulate the senses during routine care were also approached during the educative component. Specifically, participants were informed about: the importance of provide individualised sensory stimulation in order to achieve or maintain residents' well-being; and the need to incorporate residents' personal circumstances (e.g., preferences and lifestyle) into daily care. Olfaction was the first of the five senses considered. Main changes on olfaction as a result of dementia, and strategies to stimulate this sense during care were discussed

(e.g., being aware of food smells like coffee, vanilla or cinnamon; making use of fragrant oils or creams; placing scented flowers in the facility).

The supportive component aimed to help staff members to identify the positive and negative impacts that emerged from their caregiving experience. The most reported positive impacts were: personal realisation, preparation for possible personal or familiar situations in the future, satisfaction for providing the best possible care and consciousness that the residents have their needs addressed. The most cited negative impact was the fear of being, one day, in the same situation. In this session, as a relaxation method, the abdominal breathing was performed[31]. At the end, participants were given the home task of registering their sources of stress and the respective used management strategies, as a way to perceive what situations make them feel stressed.

Session two

This and the other remaining sessions began with the group members discussing their degree of success with the task that had been given in the previous session.

Communication was the first topic discussed on the educational component. Participants were elucidated about the main changes in communication of residents with dementia, including verbal and non-verbal communication, and strategies to respond to residents' requests and behaviours (e.g., making eye contact; limiting the number of open-ended questions; speaking clearly and slowly; giving sufficient time for residents to respond). Then, they were asked to narrate episodes where difficulties in communicating with a resident with dementia had emerged and to explain how they managed the situation. The group emphasised the complexity of communicating with residents who are continuously looking for relatives who have died.

The consequences of dementia on the sense of touch and strategies to stimulate it during care provision (e.g., offering different tactile opportunities with blankets, towels or clothing; massaging hands) were discussed with the group.

The supportive component aimed to help carers improving their emotion-management strategies. For this purpose, the game 'six colours to think' was used[32]. The group chose the lack of time to perform an adequate care as a situation associated with negative emotions and used the game to test how different thoughts may induce different emotions. At the end, a relaxation technique based on stretching was performed[31]. The home task of this session consisted of giving, to each participant, post-its which they had to fill with positive words or phrases, in order to enhance their positive emotions and improve self-esteem.

Session three

The educative component started with a discussion of the main changes on vision associated with dementia, and strategies to stimulate this sense during daily care (e.g., providing visually appealing meals; taking the resident for a walk outside the facility; using vivid colour pictures). Particular emphasis was placed on reality orientation strategies (e.g., calendars, watches and signposts).

In the supportive component, the different forms to communicate with others (passive, aggressive, manipulative and assertive) were presented to the group. It was explained how to communicate in an assertive way using the DESC technique[33]: Describe the facts; Express feelings; Specify the desired changes; explain the Consequences. Then, a role-play was performed to illustrate the use of this technique in a situation in which it is difficult to be assertive. At the end, participants trained a cognitive relaxation technique (guided imagery)[31]. The home task was to utilise the assertive training in at least one situation.

Session four

At the educative component, participants were alerted to the main changes that occurred in hearing due to dementia, and then asked to think in strategies to stimulate this sense (e.g., listening to familiar music; reading notices or extracts of a familiar

book; avoiding background noise; visiting a green park to hear the birds and the surrounding nature).

The supportive component aimed to help participants to improve their social relationships. Participants were invited to reflect on two questions: *Why is it important to have a social network? What can I do to keep my social network?* They reported that *it is with our social network that we talk, we share joys and sorrows, it is our basis of life*, and recognised that one way to improve their social relationships was by investing, every day, in relationships. In this session, participants performed the progressive muscle technique as a relaxation method[31]. The home task was to contact a person (colleague, friend, neighbour or family member) as a way of activating social network.

Session five

The educative component aimed to address and discuss some strategies to stimulate the sense of taste of the residents with dementia during daily activities (e.g., offering seasonal fruit or vegetables; planning menus according to traditional events, as Christmas; offering different cultural meals).

The supportive component aimed to help participants to improve their self-care. A sheet with two circles was distributed. In the first circle, participants were asked to divide the area into different portions (work, family, leisure and time for themselves), depending on the time dedicated to each of them. Then, they were asked to divide the second circle according to what they needed to be happier. After the exercise, participants reported their wish of having more time to spend with their family, more leisure time and more time for themselves. In this session, it was performed the autogenic technique as a relaxation method[31]. The home task was to generate ideas for enjoyable events and engage in one or more pleasant activities.

Session six

In the educative component, the group discussed the importance of the active participation of the people with dementia in daily activities. Some strategies to stimulate residents' engagement were shared (e.g., using skills familiar to residents; utilizing remaining functional abilities; dividing activities into simple steps; drawing on past roles and experiences).

The supportive component helped participants to address problems in an active, positive and effective way, using the problem solving technique. This technique consists of six steps: i) identify the problem; ii) explain the problem; ii) create solutions; iv) choose one solution (*dialogue*, reach agreement among colleagues); v) plan the implementation of the solution; vi) evaluate its efficacy[34]. Participants were encouraged to think about the situations of their daily routine that cause most strain. The most commonly referred problem was the unavailability of important resources to perform an adequate care to people living in the residential facility, e.g., the lack of bath chairs. This example was used to train the problem solving technique. In this session, it was performed the Mitchell's relaxation technique[31]. The home task was to practise one of the learnt relaxation techniques.

Session seven

The educative component aimed to address the behavioural symptoms that are usually associated with dementia, discuss triggers for challenging behaviours and strategies to avoid them (e.g., distracting; validating feelings; establishing routines).

The goal of the supportive component was to think on the emotions which are associated with the death of residents. The group was divided into two sub-groups: half of the participants were asked to relate their experiences about residents' death and how they coped with it; the other half observed them and then shared what they saw and eared. After that, the roles were inverted. Accepting the situation was the most common strategy mentioned to deal with the residents' death. The relaxation technique of this session was similar to the muscle progressive training presented on session

four[31]. The group participants were encouraged to bring to the last session an object that symbolised their participation in the programme.

Session eight

The last session aimed to clarify the importance of the adjustment of surroundings to create a safe living environment and ensure an increased level of comfort for the residents. Through illustrative examples of environment barriers, participants were asked to document what they observed and what they would possibly do to avoid hazardous situations. Some tips were discussed (e.g., good lighting; written and pictorial signs in significant places around the facility; minimization of obstacles in hallways).

Participants reflected about their participation in the group, described ideas for future (to maintain significant goals for their individual and professional lives) and stressed the desire to put into practice everything they learned. Finally, the end of the sessions was celebrated with a luncheon. Photographs of the whole group were taken and delivered to each participant 1 month later.

Measures

A focus-group interview was conducted 2 weeks after the end of the programme, with 5 participants (1 missed due to health problems), to explore their opinion about: functional aspects, contents and methodologies used in the programme; main benefits and disadvantages; and suggestions to better adjust the programme to their needs.

An interview guide was used. The focus-group interview was conducted by the gerontologist and the physiotherapist at the residential facility and lasted 2 hours. The interview was video-recorded, transcribed and subjected to content analysis by 2 independent judges.

RESULTS

Functional aspects of the programme

The functional aspects of the programme were positively evaluated by the participants. The majority considered the number, frequency and duration of the sessions appropriated, as they were *not overloaded.*

In addition, staff members were asked about the professional competence of facilitators. All participants emphasised the importance of the facilitators' role and agreed that the three experts complemented each other:

> *With a lot of knowledge (…) you came well prepared, knew what it was, were one step ahead ... and the psychologist was very sensitive, observer and a reasonable person (…) I noticed many times that he was very supportive!* [G., 51 years old]

Regarding the individualised assistance carried out between sessions, participants emphasised the professionals' competence and the importance of this procedure to establish changes in practice:

> *The individualised assistance reminded us what was learnt in previous sessions, we could talk and share any problem we had… it was great! (…) It was always very helpful to have additional opportunities to ask and clarify our doubts.* [C., 27 years old]

Contents and methodologies

All participants found the programme *well-structured* and emphasised that the educative and supportive components *came well together*.

Overall, the entire topics discussed along the programme were considered very important. Even though, some participants found particularly relevant the multisensory stimulation sessions as they *deal constantly with residents' senses*:

> *"I think we have to be always very aware to the senses of our residents. (...) If one is more fragile than others, we must be more aware and think ...This topic was very well developed. Senses are very important in these issues that you brought here!"* [G., 51 years]

One participant highlighted the problem-solving session:

> *The session about how to solve problems was also very interesting! It was not directly linked to residents, but to us, and that was interesting. (...) How to react to problems, how to solve them... it was very important.* [G., 51 years old]

Another participant was particularly enthusiastic about the relaxation techniques practised at the end of each session, because those final minutes were perceived as a break from routine:

> *And the final relaxation, we left ready for another day! The last part of the sessions was the best of all (...) helped us to relax in situations of great stress*... [C., 27 years old]

Moreover, all participants agreed that none particular session was useless.

Regarding the methods, materials and strategies used, participants found them adequate. The availability of handouts was highlighted, for the reason that they were written in an *understandable manner*, *without confusing words* and *very simple.*

Perceived benefits and constraints

Participants felt that they had increased their understanding about dementia and demonstrated enthusiasm to apply the new knowledge and skills into practice:

> *"Knowledge, new knowledge. I have learned a lot with this programme. We learned (...) and put* [the acquired knowledge] *into practice, which was essential."* [C., 27 years old]

Pre-existing myths often associated with dementia were challenged. The attitudes toward the residents had changed, because participants previously thought that almost nothing could be done with people at advanced stages of dementia. The programme provided staff members with a better idea of what works well with residents, showing that there are strategies, like MSS and MS, they can integrate in the provision of personal care to communicate appropriately with them:

> *"Some* [strategies] *I had already put it into practice but others…I experienced many. It was impressive! We thought they were not able to do nothing, for example Mr. F., and he really does a lot."* [C., 27 years old]

The sessions were helpful in enabling staff members to reflect on their own practice. For example, one participant referred that they had previously used some of the skills approached during the sessions; however, they were not aware of their importance when caring for residents with dementia:

"Sometimes it was like a 'click'...for some points that you warned we thought 'we really seem to do these things and not reflect in what we are doing'. And you allowed us to reflect." [G., 51 years old]

The programme also contributed to validate competences. Several participants reported feeling valued, as they identified that the abilities they had acquired during their caregiving experience were recognised as adequate and validated by the facilitators:

"I think it also helped us to understand whether the things we did and the decisions we took were right or not… now we realize that we acted exactly the way we should. It makes us more certain of our decisions." [P., 45 years old]

Moreover, the initial resistance to the provision of new care practices, like the application of MS and MSS during the provision of personal care, was dissipated, with one participant reporting that:

"At the beginning, making a first judgment, I thought it was all very theoretical. It was good, but maybe not to put into practice and (...) I really saw that it could be used in practice." [P., 45 years old]

Overall, staff members valued the supportive component. The programme was an opportunity to increase the group cohesion and to discuss difficulties and experiences together. It promoted a greater proximity between members and increased feelings of belonging, by allowing the dialogue and confrontation of different perspectives:

"When we joined, one spoke about a thing, another of another thing (…) and we reflected together." [M., 45 years old]

"Sometimes we meet in the lobby and it is just a 'hello!', but here we had the opportunity to know a little bit more of each other." [P., 45 years old]

Additionally, the supportive component also contributed to enhance participants' problem-solving skills, by supporting them with solutions to their problems:

"That part of working with the colleagues, of us to react to a problem...how to solve problems... was very important. Because I had a problem, but in many occasions it was never solved, and I thought that it would not be solved anyway. But I tried and resulted! [G., 51 years old]

Participants emphasised the importance of relaxation techniques. These enabled them to understand that caring for themselves could improve their work performance and, therefore, residents' well-being:

"I think that the moments of relaxation helped us to understand that if we feel happy, we can contribute to the well-being of the elderly." [G., 51 years old]

In general, residents were perceived as the beneficiaries of staff involvement in the programme:

All this here is an accomplishment! They do not lose anything…we have been here investing for them! [G., 51 years old]

Time restraint was perceived as the main obstacle for programme participation. Sessions deprived workers from the little free-time they had to *rest*.

As for suggestions, different members recommended the inclusion of other conditions besides dementia, as they care for residents with a range of different pathologies:

> *I just think that more aspects could have been developed, as it is not just the dementia that exists in these homes!* [G., 51 years old]

Participants stated the wish of having *more of this type of initiatives* and emphasised the need of regular meetings with all staff, to share concerns and difficulties.

DISCUSSION

Overall, the results suggested that staff members responded positively to the psycho-educational programme. The combination of educational and supportive components revealed to be adequate and helpful to meet participants' needs and expectations.

With regard to the benefits, the psycho-educational programme contributed to increase staff knowledge and skills on dementia and demystify pre-existing believes related to dementia care. The topics on practical skills for delivering MS and MSS were noticeably appreciated by staff. Previously to the intervention, participants felt that nothing more could be done with the residents with dementia. However, after the programme, they found that residents at advanced stages of dementia can respond to the MS and MSS and are able to continue communicating and interacting. An additional factor that might explain the relevance attributed to MS and MSS is that these approaches are under staff's control, i.e., they do not require a lot of time and effort to implement them in practice. The emphasis attributed to these topics underline the need of its inclusion in future programmes.

Also, the individualised assistance and orientation given by the facilitators between sessions was emphasised as fundamental to guarantee knowledge and change practice. In the majority of previous interventions, participants acquired new knowledge and skills but encounter difficulties when attempting to transfer them into practice[35]. This study allowed participants to apply what they have learned during sessions, and simultaneously receive feedback and orientation. Such procedure was recommended before[5, 36, 37] due to its potential to increase motivation to change staff's performance and sustain behaviour changes over time.

Unlike previous studies, which have primarily focused on staff educational needs, this research had a broader focus: it also attended to staff's emotional support needs. Concerning this, participants acknowledged that the programme: helped them to feel valued and recognised in their efforts and competences; provided them with new problem-solving skills related to work demands; and increased awareness to the importance of their own well-being. Therefore, interventions leading to perceptions of increased competence and feelings of being attended in emotional needs, such as the programme described in the current study, might enhance staff motivation and engagement in providing adequate care. Moreover, the programme had provided an opportunity for participants to share and listen their colleagues, enabling group cohesion. Actually, participants reported that they often feel unsupported, and had identified the need of a period during their work-time where they could discuss their problems and share experiences. This finding is in accordance with a previous study, which has shown that over 30% of staff members in residential facilities have not enough opportunities at work to discuss the psychological stress of their job[20].

As noted earlier[5, 37], limited time was cited as the main barrier to the implementation of the programme. Insufficient human and financial resources that commonly characterise residential facilities and the limited incentives for staff to attend sessions[37]

can explain time constraints. This finding highlights the need to pay more attention to organisational issues, i.e., it is important to extend the focus of interventions beyond the staff and include the entire organisation in order to stimulate and promote change.

In general, findings from this pilot-study suggest that interventions that attend to both educational and supportive needs of staff are a promising approach to improve dementia care in residential facilities. Despite the promising results, the current study presents some limitations. First, staff's participation was voluntary, thus the programme likely attracted individuals who were among the most interested and motivated. Moreover, findings are limited by the inclusion of a single residential facility and a small sample. The authors recommend the development and assessment of similar interventions in larger samples, and the inclusion of further residential facilities and control groups in order to explore the extent of benefits.

CONCLUSION

Direct care workers provide the majority of hands-on care to individuals with dementia residing in residential facilities, yet they present insufficient specialized training in dementia care and are poorly supported and valued for their physically and emotionally labour-intensive care[6, 38, 39]. Findings, although preliminary, suggest that psycho-educational approaches can be implemented in residential facilities. This approach might improve staff's sense of mastery and self-competency and, therefore, enhance the quality of care and well-being of both staff and residents.

Providing a high standard of care for people with dementia is becoming an increasingly important issue as societies continue to age. Psycho-educational approaches might be effective in assisting staff to have the necessary tools to provide excellence in care. Further studies, with larger samples, using further residential facilities and having control groups, are needed in order to investigate the extent of these benefits.

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Table 1. Characterization of staff participants (n=6)

Variables		
Gender		
Female (n, %)	6	100
Age		
Mean, SD (years)	40.0	11.91
Minimum, maximum (years)	23	51
Academic qualifications		
1st cycle (n, %)	1	16.67
2nd cycle (n, %)	1	16.67
3rd cycle (n, %)	1	16.67
Secondary school (n, %)	1	16.67
Higher School (n, %)	2	33.33
Working years in the institution		
Mean, SD (years)	5.00	5.99

Table 2: Psycho-educational sessions for staff

Sessions	Components
Session 1.	Education: Presentations. Information about dementia. Stimulate olfaction. Support: Emotional impact of caregiving. Abdominal breathing (relaxation). Home task.
Session 2.	Education: Review of the home task. Communication in dementia. Stimulate tact. Support: Deal with emotions. Stretching (relaxation). Home task.
Session 3.	Education: Review of home task. Stimulate vision. Support: Assertiveness. Guided imagery (relaxation). Home task.
Session 4.	Education: Review of home task. Stimulate audition. Support: Social support. Progressive muscle technique (relaxation). Home task.
Session 5.	Education: Review of home task. Stimulate taste. Support: Self-care. Autogenic technique (relaxation). Home task.
Session 6.	Education: Review of home task. MS. Support: Problem-solving. Mitchell method (relaxation). Home task.
Session 7.	Education: Review of home task. Challenging behaviours. Support: Cope with grief. Progressive muscle training (relaxation). Home task.
Session 8.	Education: Review of home task. Adjust environment. Celebration and close of the group

Note: MSS= Multi-sensory stimulation; MS= Motor Stimulation